**Texas Department of Insurance**
***Division of Workers' Comp***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SOUTHWEST FRWY, SUITE 2200
HOUSTON TX 77027

**Respondent Name**
METROPOLITAN TRANSIT AUTHORITY

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-09-4745-01

**MFDR Date Received**
January 15, 2008

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "On September 27, 2007, Division of Workers' Compensation dismissed the dispute on the basis there was an unresolved medical necessity dispute that had not been reviewed by an independent review organization. Based upon your dismissal, I requested an IRO with the employer. However, the employer denied my IRO request because the issue is whether preauthorization/concurrent review was obtained (a fee dispute), not whether the services were medically necessity, requiring an IRO."

"It is the hospital's position that the hospitalization was an emergency as defined pursuant to the Acute Care Hospital Fee guideline. Metropolitan Transit Authority issued an underpayment of $1,945.38 as a fair and reasonable reimbursement for trauma admits."

**Amount in Dispute:** $30,618.14

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "This claim was initially denied as not compensable. Then following an administrative determination on that issue the carrier/self-insured accepted a lumbar sprain/strain." "Further, the carrier challenges whether the charges are consistent with applicable fee guidelines. The carrier asserts that it has paid according to applicable fee guidelines. All reductions of the disputed charges were appropriately made."

Response Submitted by: S. Rhett Robinson, Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, TX 78701

## *SUMMARY OF FINDINGS*

| Date(s) of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 10, 2006 through September 22, 2006 | Inpatient Services | $30,618.14 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.308 sets out the procedures for resolving medical necessity disputes.
3. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
4. 28 Texas Administrative Code §134.600, effective May 2, 2006, 31 TexReg 3566, requires preauthorization for non-emergency inpatient hospitalizations.
5. 28 Texas Administrative Code § 133.305(b) outlines the "Dispute Sequence."
6. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
7. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W11-Entitlement to benefits. Not finally adjudicated.
   - Claim is denied.
   - Payment recommended per CCH Decision & Order plus interest. Recommend one day medical admit and fair & reasonable for MRI and ER. Medical necessity or preauthorization for continued stay is not supported.
   - W3-Additional payment made on appeal/reconsideration.
   - W1-Workers Compensation State Fee Schedule Adjustment.
   - W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
   - 97-Payment is included in the allowance for another service/procedure.
   - W7-Payment of interest/penalty to provider.
   - Global of required documentation.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

**Findings**

1. The respondent denied reimbursement based upon EOB denial reason code "W11-Entitlement to benefits. Not finally adjudicated" on the initial EOB. The Division finds that on the reconsideration EOBs, the respondent did not maintain this denial reason upon reconsideration. On March 22, 2007, a Contested Case Hearing Decision and Order was issued that found that the claimant sustained a compensable low back injury on September 9, 2006. Additionally, the insurance carrier was ordered to pay for the benefits; therefore, an entitlement issue does not exist and the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.600(c)(1), states that "c) The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;
   (C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or
   (D) when ordered by the Commissioner."

   The claimant sustained a compensable injury on September 9, 2006 when claimant was involved in a motor vehicle accident.

   The respondent paid for the initial day of treatment and denied the remaining eleven days based upon "Medical necessity or preauthorization for continued stay is not supported."

3. The requestor states in the position summary that “On September 27, 2007, Division of Workers’ Compensation dismissed the dispute on the basis there was an unresolved medical necessity dispute that had not been reviewed by an independent review organization. Based upon your dismissal, I requested an IRO with the employer. However, the employer denied my IRO request because the issue is whether preauthorization/concurrent review was obtained (a fee dispute), not whether the services were medically necessity, requiring an IRO.”

   28 Texas Administrative Code § 133.305 (a)(7) states “Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this subchapter (relating to MDR by Independent Review Organizations).”

   The Division finds that based upon the EOB this dispute contains unresolved preauthorization or concurrent medical necessity issues and is applicable to 28 Texas Administrative Code §133.308.

4. 28 Texas Administrative Code § 133.305(b) states “Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.”

   The Division finds that the requestor again filed a fee dispute prior to the resolution of the medical necessity issues.

5. The respondent denied reimbursement for dates of service September 11, 2006 through September 22, 2006 based upon “Payment recommended per CCH Decision & Order plus interest. Recommend one day medical admit and fair & reasonable for MRI and ER. Medical necessity or preauthorization for continued stay is not supported.”

   28 Texas Administrative Code §134.600(q)(1) effective May 2, 2006, requires preauthorization for concurrent review for an extension of “inpatient length of stay.”

   The Division finds that the requestor did not obtain preauthorization approval for concurrent review for inpatient hospitalization in accordance with 28 Texas Administrative Code §134.600(q)(1); therefore, additional payment is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is not due. As a result, the amount ordered is $ 0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | 7/27/2012 |
| Signature | Medical Fee Dispute Resolution Officer | Date |
| | | 7/27/2012 |
| Signature | Medical Fee Dispute Resolution Manager | Date |

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.